iii. EXECUTIVE SUMMARY

INTRODUCTION

State Health Care Expenditures: Experience from 1998 describes Maryland's large and complex health care market in terms of the level, growth rate, and patterns of health care spending for the state's residents. The report, the first analysis of total health care expenditures by the Maryland Health Care Commission (MHCC), follows the organization of previous reports issued by the Health Care Access and Cost Commission (HCACC).[1] To enable policymakers to better understand the level and rate of change in expenditures, this report provides information on factors that contribute to health care expenditures including health care needs, access to insurance coverage, and available health system resources. Health care expenditures are the primary focus of this report. They are presented overall, for specific provider categories, and contrasted by type of payer and delivery system. An entire chapter is devoted to regional health care expenditures and the factors that drive these expenditures.

The development of this report required extensive information obtained from a variety of state and federal agencies, as well as private organizations. The principal state agencies that supplied information are the Maryland Insurance Administration and the Department of Health and Mental Hygiene. Federal agencies – including the Health Care Financing Administration and the Office of Personnel Management – provided information on expenditures and enrollment in federally-funded health plans. Private sector organizations, including the American Association of Retired Persons and the American Medical Association, provided information on health care resources.

CHARACTERISTICS OF MARYLAND'S HEALTH CARE MARKET PLACE

The magnitude, pattern, and growth rate of health care spending differs from year to year and from region to region and this report presents information on variables known to influence health care use. The volume of health care spending for different services in the state results from choices made in regional health care markets. Underlying these choices are demand, supply, and price characteristics that generally differ from region to region. Demographics, health status, health insurance coverage, the economic status of the population, the availability of health care resources, and differences in physician practice style influence supply and demand. Some of the specific findings include:

- ***Although Maryland is below the national average in health status of African-American infants, as reflected by higher infant mortality and a larger percent of low birth weight newborns, rates improved for both measures in 1998.*** For the first time, however, the state fell below the national average in immunizations for all young children between 19 and 35 months of age.

- ***Maryland's smoking rate rose in 1998 while that of the nation declined, making the state's rate only slightly better than the national average.***

- ***Compared to 1996, actual death rates in the state fell for malignant neoplasm, cerebrovascular disease, accidents, diabetes, and homicide, and increased for heart and chronic pulmonary diseases.*** Maryland's age-adjusted mortality rates are lower than the national averages for six of the top twelve causes, specifically those that are most directly influenced by preventive efforts (excluding HIV). The state's age-adjusted death rates from homicide and diabetes surpassed the national averages by the greatest margins, and the death rate for HIV, a highly preventable disease, continues to surpass national averages.

[1] Previous state health expenditure reports were issued by the Health Care Access and Cost Commission which merged with the Maryland Health Resources Planning Commission in October 1999 to form the MHCC. This is the second year in which the state health expenditure analysis has been issued in a report separate from other analyses.

- ***The reported case rate of AIDS in Maryland for 1998 was the fourth highest in the nation.*** Maryland, principally due to the City of Baltimore, also ranked high in rates of sexually transmitted diseases in 1998.

- ***Maryland residents, regardless of race, are more likely to have health insurance coverage than the national average.*** Compared to the nation, state residents are more likely to be covered by private insurance and those with Medicare are more likely to have supplemental insurance. ***Maryland continues to be one of the wealthiest states in the nation with measures of per capita and family income above the national averages and a poverty rate 35 percent below that of the nation.*** However, about 13.8 percent of the state's residents do not have insurance and the uninsured rate among minorities is more than twice that of whites. Also, the benefit of residing in Maryland depends on income level. Those with family incomes above the national median are more likely to be insured if they reside in Maryland while those with incomes below the national median are less likely to be insured.

- ***Maryland's HMO enrollment continues to be among the highest in the nation with 35 percent of all residents, approximately 1.8 million persons, served by HMOs compared with 29 percent of the population nationwide.*** HMO enrollment grew by 7.1 percent in 1998, less than in 1997, and all growth occurred in the public sector while private sector enrollments were stable. The full implementation of Maryland Medicaid's HealthChoice accounts for most of the public sector enrollment growth. The influence of HMOs on health care markets nationwide has resulted in an expansion of benefit coverage in traditional insurance products and more cost-conscious treatment by physicians for all patients, regardless of insurance coverage.

STATE HEALTH CARE EXPENDITURES

Maryland experienced a 5.3 percent rate of growth in total health care expenditures in 1998, up from the 4.3 percent 1997 increase. The 1998 rate of increase is similar to the national rate for comparable expenditure categories as estimated by HCFA in the National Health Care Expenditure accounts. Since 1994, total state expenditures have increased by about 20.5 percent while national spending grew by 20.1 percent over the same period. ***Total health care spending for Maryland residents grew in 1998 to $17.0 billion from $16.2 billion in 1997. Including administrative expenses, the average per capita expenditure across all residents for all services in 1998 was $3,316, up 4.5 percent from $3,173 in 1997***. Health care expenditures, as a share of Maryland residents' personal income, is 11 percent. This figure has held constant with the most recent estimates from 1997 suggesting increases in personal income have kept pace with increases in health care expenditures.[2] Health care expenditures, as a percent of personal income, remain at the lowest level since the state began reporting this statistic in 1995.

Medical price inflation accounts for about half of the 5.3 percent growth in total expenditures. From 1997 to 1998, the Consumer Price Index (CPI) for medical care services increased about 3.4 percent nationally. However prices increased by 2.6 percent in the Baltimore/Washington DC Metropolitan Area compared to the U.S. city average of 3.4 percent. Another 1 percent of growth is attributable to population increases. Other non-quantifiable factors that could have driven the increased utilization include increased enrollment in government programs, the aging population, and expansions in benefit coverage and the types of services available (e.g. new drugs). Key findings for leading health care provider and primary payer categories are summarized as follows.

[2] Personal income for Maryland residents was $145 billion in 1997 and $154 billion in 1998.

Leading Health Care Categories

- ***Hospital care accounts for the largest share of expenditures, 34.1 percent of total health care dollars, but the percent share continues to fall and is down from 34.4 percent in 1997.*** Hospital services as a share of total health care expenditures have decreased each year since 1995. Payments for hospital services total $5.8 billion when estimates for public sector capitated payments are included. Inpatient hospital expenditures increased by 3.6 percent and outpatient services grew by 6.4 percent. Medicare accounts for 44 percent of inpatient payments but private payers account for almost 55 percent of outpatient services.

- ***Expenditures for physician services, including capitation payments increased by 7.7 percent in 1998***. Physician services as a share of total health care expenditures increased from 24.4 percent of total expenditures in 1997 to 24.9 percent in 1998. Increased service volume and greater resource intensity may have contributed more to overall growth than physician price inflation which was up 3.3 percent in 1998 as measured by the CPI. In 1998, private payers and patient out-of-pocket payments account for 79 percent of the $4.2 billion in payments for physician services. The physician payments made by Medicare and Medicaid through traditional indemnity programs declined by 13 percent as enrollment through these programs increasingly shifted to managed care. Private sector non-HMO payments to physicians increased by almost 7 percent.

- ***Other professional health care services, including those provided by non-physician health care providers and organizations such as ambulatory surgery centers, accounted for 11.1 percent of expenditures in 1998. This figure is down slightly from the 11.4 percent share in 1997.*** Private payers and patient out-of-pocket expenditures are responsible for 66 percent of spending in this category. Out-of-pocket payments, including uncovered services and patient co-payments and deductibles, account for 48 percent of payments to these providers. The high out-of-pocket percentage reflects the limited insurance coverage that exists for many services in this category.

- ***Payments for sub-acute care services declined in 1998. Nursing homes and home health agency expenditures fell 6.6 percent and 4.5 percent, respectively, in 1998.*** Declining nursing home occupancy rates and the 1997 Federal Balanced Budget Act (BBA) were major contributors to these declines. Home health expenditures under Medicare dropped as a result of both antifraud activities and the cautious response by home health agencies to limit the average payments per beneficiary under the interim payment system imposed by BBA. Maryland expenditures for home health services fell more rapidly than national expenditures in this sector.

- ***Prescription drug expenditures jumped by 13 percent, the most rapid increase of any major expenditure category.*** These expenditures increased despite tighter plan management, including growing use of drug formularies, and increased patient co-payments. These forces were not able to offset demand for new drugs caused by advances in drug treatment protocols and increased direct marketing of prescription drugs to consumers. Dramatic price increases for new drugs fueled the higher expenditures nationwide and the monthly CPI for prescription drugs increased at an annual of rate of 4.9 percent in 1998. The Producer Price Index, which captures prices paid by consumers and third party payers, showed prescription drugs increasing at a yearly rate of 20.9 percent through 1998. One particular cause for concern with these increases is that although prescription drugs substitute for or are used in conjunction with expensive services, little information exists on how much prescription drugs offset other medical services.

Leading Payer Expenditures Categories

Most public and private payers experienced strong expenditure growth in 1998. Maryland's 1998 rate of growth for government payers was 4.4 percent. Government spending on health care totaled $7.3 billion or 42.8 percent of total expenditures, down from 43.2 percent in 1997.[3] Decreased spending for other government health programs accounts for virtually all the decline. Medicare and Medicaid, the two primary government programs, account for 37.9 percent of total health care spending, unchanged from the share in 1997. Factors contributing to the greater Medicare and Medicaid spending include modest enrollment increases as well as rising expenditures for hospital care and physician services. Spending growth in the private sector, including private health insurance and out-of-pocket spending by consumers, increased by 6 percent, ending the trend of lower private sector spending growth. Although enrollment was nearly flat for both, private non-HMO spending increased by 7.8 percent and HMO expenditures jumped 6.3 percent. Out-of-pocket spending, which includes direct payments by consumers for deductibles, co-insurance, and uninsured products and services, increased by 3.3 percent. Direct per capita expenditures, including out-of-pocket expenses for the insured population, increased from $2,803 to $2,942 in 1998, a 5.0 percent increase.[4]

- ***Medicare expenditures increased by 5 percent in 1998 bringing total Medicare expenditures to $3.8 billion. Enrollment in Medicare grew by 1.4 percent, a reflection of continued aging of the Maryland population.*** Average per capita spending for Medicare beneficiaries program-wide rose 0.2 percent from $6,330 in 1997 to $6,345 in 1998. The small increase for Medicare is due in part to ***HMO growth as reflected by the 52.6 percent increase in expenditures***. Programmatic changes brought about by the Balanced Budget Act of 1997 reduced Medicare reimbursement for various covered services in 1998, however, Congressional action in 1999 will reduce future savings.

- ***Medicaid expenditures increased 6.3 percent in 1998, from $2.5 billion to $2.7 billion. A small portion of this increase was due to the introduction of the Children's Health Insurance Program (CHIP), which expands coverage to children and expectant mothers up to 200 percent of poverty.*** Even though Medicaid represents only 15.7 percent of total Maryland expenditures, it funds almost half of all nursing home and home health expenditures in the state. Medicaid funds proportionately less than its total share of expenditures for hospital outpatient, physician, and other professional services, but part of this is due to the high level of expenditures for nursing home and home health care.

- ***Private insurance funded 40.2 percent of total state health expenditures and is up from 39.4 percent in 1997***. This result reverses a recent trend in which private payers account for declining shares of health expenditures. The increased private share reflects the BBA impact under Medicare and government's somewhat improved ability to control cost in 1998. Much of the private sector growth appears driven by higher utilization with an increase in per capita expenditures by 6.7 percent from $1,823 in 1997 to $1,946. Expenditures grew for all service categories with prescription drugs making the most rapid climb, increasing 15.1 percent.

- ***In 1998, out-of-pocket spending in Maryland increased by 3.3 per cent with the out-of-pocket share of total spending at 16.7 percent.*** Growth in out-of-pocket expenditures was driven by an increase of 5.2 percent in expenditures on prescription drugs and an increase of 5.8 percent in other professional services, while other categories of services showed smaller increases, or even declines, in their out-of-pocket expenditures. Differences in the rate of increase for particular provider categories reflects differing cost sharing arrangements that exist for major payers and different delivery systems.

- Private HMOs and other forms of tightly managed care through government payers continued to grow in 1998. Enrollment increases occurred entirely in the government sector, but the private sector also saw a jump in HMO expenditures***. HMOs now account for about 29 percent of all third party payments in the state, up from 23.7 percent in 1997***.

[3] This does not include government funded health spending for health insurance premiums for government employees.

[4] Excludes administrative expenses and the net cost of insurance.

REGIONAL HEALTH CARE EXPENDITURES

Regional differences in the use of health care services are attributable to a host of factors. Racial composition and age distributions tend to shape health care needs and preferences. The proportion of minorities ranges from 31 percent in the Baltimore Metropolitan Area to 7 percent in Western Maryland. The Eastern Shore has the oldest population, while Southern Maryland is home to the youngest. Regional diversity also exists in the availability of treatment resources, which influences what services are utilized. The supply of hospital beds and physicians ranges from 133 beds and 104 physicians per 100,000 population in Southern Maryland to 326 beds and 356 physicians per 100,000 residents in the Baltimore Metropolitan Area. The mix of payers serving a region and the delivery systems offered affects expenditures as coverage packages and prices paid to providers differ. ***Due to the complex interaction of factors, significant differences exist between the proportion of the population living in a region and the proportion of state health care expenditures spent on that population.*** The National Capital Area constitutes 31.5 percent of the population of the state but this region accounts for 29.3 percent of health care expenditures. Conversely the Baltimore Metropolitan Area represents 47.6 percent of state population and uses 50.9 percent of resources. The less urbanized portions of the state, including Western and Southern Maryland, and the Eastern Shore, use a smaller share of health care services than they represent in share of the state population. Differences between the regional population and spending distributions are reflected in regional variations in per capita spending. The Baltimore Metropolitan Area has the highest expenditures per capita at $3,277. The four remaining regions have expenditures per capita ranging from $2,851 for the National Capital Area to $2,947 for Western Maryland. Specific findings regarding the distribution of payments are briefly summarized below.

- ***Private payers, including private insurance and out-of-pocket spending, paid for the majority of expenditures in all regions except the Eastern Shore where they accounted for 49.4 percent of total expenditures.***

- ***Spending by all public payers - Medicare, Medicaid, and other government spending - ranged from a maximum of 50.6 percent of the health expenditures on the Eastern Shore to a minimum of 35.4 percent in Southern Maryland.*** Public spending covered slightly more than 48 percent of expenditures in Baltimore and Western Maryland - above the statewide figure of 44.3 percent - but just 36.4 percent of total spending in the National Capital Area.

- ***Medicare payments were most important on the Eastern Shore, where they amounted to 25.1 percent of total health expenditures.*** Medicare payments were almost as significant in Baltimore and Western Maryland where Medicare covered a higher proportion of total regional expenditures than the state total of 23.1 percent.

- ***Medicaid's importance as a payer was greatest on the Eastern Shore, where it covered 19.6 percent of the region's health care spending.*** It was nearly as significant a payer in Baltimore and Western Maryland where it covered 18.3 percent of these regions' expenditures. Medicaid payments were least important in the National Capital Area, where they amounted for just 11.5 percent of total expenditures.

CONCLUSIONS

Maryland's favorable economic climate in 1998 enabled consumers and employers to keep pace with accelerating health care spending over the year. However, policymakers must be aware that health care costs over the long term play the dominant role in the cost of health care premiums. Factors, such as competition among health plans, pressure from employers to control costs, and the shift of Medicaid enrollees to managed care plans, that contributed to a dramatic slowdown in the growth of health care expenditures in the middle 1990s appear to have weakened in 1998.

With a strong and growing economy, policymakers and the public have renewed interest in expanding health care coverage. Benefits for the uninsured and mandating coverage of additional services are being considered. Indeed, despite the introduction of the CHIP program, the number of insured in the state is keeping pace with the population growth. Clearly, more can and should be done. Carefully framed expansions in health care coverage for the uninsured have the potential for reducing long term health care expenditures. The passage of mandates requiring payers to offer a defined benefit or to guarantee access to a group of providers continues to be a significant source of uncertainty about future growth in health care expenditures. ***Although a single benefit may have little apparent consequence on health care expenditures, and ultimately premiums, the cumulative impact can be significant***. Recent studies conducted by the federal government and private research organizations have found that despite increases in the number of employers offering employer-sponsored coverage, the number of employees accepting coverage has fallen.[5] The growing costs of insurance premiums are often the cited reason for declining coverage. A substantial increase in costs could further erode the ability of workers to afford health insurance.

[5] See The Uninsured in America – 1997. Rockville MD: Agency for Health Care Policy and Research; 1999. *MEPS Highlights No. 10.* AHCPR Pub. No. 99-0031; Agency for Health Care Policy and Research. Who declines employer-sponsored health insurance and is uninsured? Issue 23, November 1999. Center for Health System Change.

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